The Healing OM

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Please complete this document as thoroughly as possible. Some questions below may seem unrelated to your condition but play a major role in diagnosis and treatment. All information is strictly confidential and will not be released unless you have authorized us to do so.

Patient Information

Name_____ Date_____
Address_____City_____ State___ Zip_____
Home Phone_____ Work Phone_____ Cell_____
Email_____
Would you like to receive a free email newsletter (email information is held in complete confidence.) Yes No

Height_____ Weight_____ Age____ Sex: Male Female Dominant hand: Left Right
Date of Birth:_____ Marital Status:_____
# of children:_____ Ages of children:_____ # who live in household:_____
Occupation:_____ Employer:_____

Primary Care Doctor_____Last seen:_____
How did you hear about our office?_____
Referred by:_____
Other Physicians/therapists seen for your condition:_____

Medications: Please list all medications and supplements you are currently taking.

Drug/ Supplement	Reason for taking	For how long	Dose	Frequency

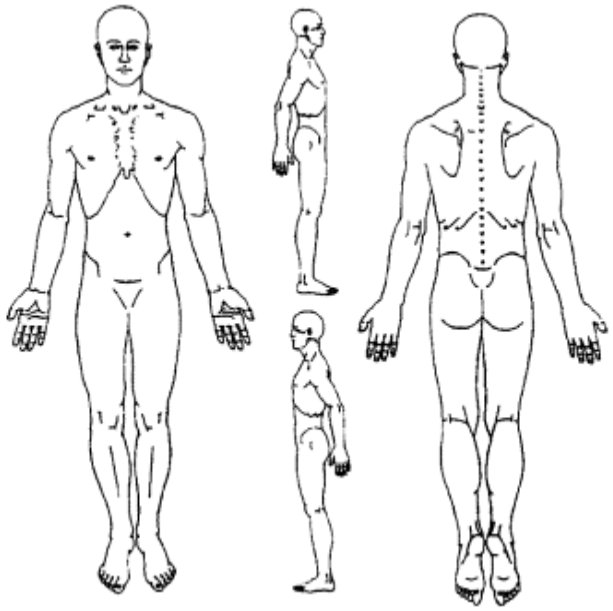
Allergies:_____
Vaccinations since 2019 including Covid 19 and Flu shot, including
date:_____
I am taking Coumadin/Warfarin: Yes No
I have a pacemaker: Yes No

Lifestyle

Are you vegetarian or vegan? Yes No If Yes, how long?_____
Do you smoke? Yes No If yes, how much?
Do you drink coffee? Black tea? Yes No If yes, how much?_____
Do you use alcohol? Yes No If yes, how much?_____
Do you exercise? Yes No If yes, how often?_____What type?_____

Pain

Please answer the following questions if you have pain. Indicate on the diagram your areas of pain. Circle as many answers that apply.



Quality of pain: Dull Sharp Stabbing Sore Cramping Burning Constant Fixed Moves around

On a scale of 1-10 (10 being the worst) how strong is your pain?_____

Does the pain radiate? Yes No Where?_____

What helps the pain? Ice Heat rest Movement Pressure Moisture Massage Nothing Other:_____

What aggravates the pain? Ice Heat Rest Movement Pressure Moisture Massage Nothing Other:_____

Other treatments you have had for your pain?_____

Cause of pain? Injury/Accident Disease Unknown
Details:_____